



U.S. Department of Veterans Affairs

Honoring Our Heroes:

Building Partnerships to Connect
Native Veterans to Care and Benefits

Tribal Consultation Report | 2016

VA



U.S. Department of Veterans Affairs
Office of Tribal Government Relations



Office of
Tribal Government
Relations

Abbreviations, Terms, and Definitions

Abbreviations/ Terms	Definitions
CBO	Veterans Health Administration Chief Business Office
The Choice Act	The Veterans Access, Choice, and Accountability Act of 2014, Public Law 113–146. The Choice Act, as amended, established the Veterans Choice Program under which eligible Veterans receive care through non-VA providers.
CMOP	VA's Consolidated Mail Order Pharmacy
HUD-VASH	U.S. Department of Housing and Urban Development-VA Supportive Housing program, a supportive case management and housing voucher program to assist homeless Veterans
IAA	Interagency Agreement
IHS	Indian Health Service
MOU	Memorandum of Understanding
MyVA	A transformation initiative started in 2014 by VA Secretary Robert McDonald to improve agency performance and the quality of care for Veterans
NADL	Native American Direct Loan program
OMB	Office of Management and Budget
OTGR	VA Office of Tribal Government Relations
PRC	Purchased/Referred Care, a program under Indian Health Service that allows eligible patients to receive care from other private (non-IHS) providers when appropriate
PTSD	Post-traumatic stress disorder, a mental disorder related to exposure to trauma, with diagnostic criteria defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5)
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VSO	Veterans Service Organization, an organization recognized by VA as qualified to represent Veterans in claims for VA benefits



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Introduction

Of all population groups in the United States, American Indians and Alaska Natives continue to serve in the military at the highest rate of all races, as they have done throughout our Nation's history.

In 2016, VA initiated consultation with American Indian and Alaska Native tribal governments on three topics:

- recognition of tribal organizations for representation of VA benefit claimants,
- top three to five priorities for Veterans in Indian Country, and
- a proposed consolidation of non-VA care into a more standardized system under the Veterans Choice Program.

This report presents tribal responses and policy background for each consultation topic. It highlights the top priorities identified through tribal consultation in a special section that begins on page 8.

Reporting on tribal government input received through consultation offers a valuable mechanism for VA agencies to stay informed about the impacts of their policies and proposed actions in Indian Country and to be responsive to the needs identified by tribal governments for effectively serving Veterans.

The audiences for the 2016 tribal consultation report include the following:

- **Tribal nations**, including those who participated in 2016 consultations and those who did not, so they can see the tribal input on current policies and priorities that has been received by VA.
- **VA**, so VA leadership can consider and be informed by the experience, voices, and perspectives of tribal leadership, which offer critical, first-hand insight about the effects of proposed policy or programmatic changes on Veterans living in Indian Country.
- **Congress**, to demonstrate the ways VA upholds its legal mandate to consult with tribes, and so Congress can be informed about recommendations that tribal governments believe would enable VA programs to deliver benefits to Veterans and fulfill VA's mission more effectively.



Soy Redthunder

Mr. Redthunder addresses Tribal Veteran representatives and advocates at the OTGR 2-day training for Tribal Veteran Representatives.

Three Tribal Consultations in 2016

VA's Office of Tribal Government Relations (OTGR) facilitates VA's relationship with tribal governments and American Indian and Alaska Native Veterans and helps VA implement its Tribal Consultation Policy. As part of those responsibilities, OTGR worked with VA and tribes to conduct consultation on three topics in 2016:

- **Consultation 1:** Recognition of tribal organizations for representation of VA claimants,
- **Consultation 2:** Top three to five priorities for serving Veterans in Indian Country, and
- **Consultation 3:** The proposed consolidation of non-VA care into a standardized system under the Veterans Choice Program.

Each consultation was initiated by a notice in the *Federal Register* and a Dear Tribal Leader letter from VA sent to all federally recognized tribal governments. These notices identified the issues for which VA requested consultation input, offered background about the current status of those issues, and, in some cases, communicated proposed or possible policy changes.

Consultation feedback received from tribes is reported in the following sections for each consultation topic. The section *Top Priorities for Veterans in Indian Country*, on page 8, discusses the 23 priorities identified through tribal consultation. Also included, where available, are updates from VA on policy changes or continued development on the topic that has occurred since the consultation period.



Vietnam War Native American Veteran and Commander Trickster Veterans group



Consultation 1:

Recognition of Tribal Organizations for Representation of VA Claimants

In the first consultation topic of 2016, VA asked tribes to comment on a proposed rule relating to the recognition of tribal organizations. The proposed rule would amend Title 38, Part 14, of the Code of Federal Regulations to recognize tribal organizations that meet the requirements to assist American Indian and Alaska Native claimants with their VA benefits, and alternatively, to allow Tribal government employees to pursue accreditation through existing State organizations.

The goal of the proposed rule is to provide for the needs of American Indian Veterans who might be served by VA-recognized organizations, but are unable to use existing national, State, and local organizations because of geographic isolation, cultural barriers, or a lack of familiarity with non-tribal Veterans' resources.

This consultation topic was not supported by an in-person consultation event. It was introduced by letters to tribal leaders, and all feedback was collected via mail, email, or fax. (See Appendix B, page 44, for the full Dear Tribal Leader letter text.) VA hosted a webinar explaining the proposed rule and answering questions.

Consultation 1 Topic and Questions

Recognition of tribal organizations to represent Native Veterans for VA benefits claims

Consultation Period

March 3, 2016 – April 3, 2016

Dear Tribal Leader Letter

Released March 3, 2016.

See Appendix B, page 44, for the full text of the letter.

Webinar

(No consultation event)

Available online: <http://www.anymeeting.com/091-256-324/E953D68584493D>

VA Consultation Updates

On January 19, 2017, VA amended its regulations consistent with the approach that was set forth in this consultation. The new rule became effective on March 21, 2017. Notices in the *Federal Register* documenting these changes can be found online at <https://www.federalregister.gov/documents/2017/02/21/2017-03328/recognition-oftribal-organizations-for-representation-of-va-claimants-delay-of-effective-date>

Consultation 2: Priorities for Serving Veterans in Indian Country

Consultation 2 Topic and Questions

Top 3–5 priorities for serving Veterans in
Indian Country

Consultation Period

May 19, 2016 – October 7, 2016

Dear Tribal Leader Letter

Released May 19, 2016.

*See Appendix C, page 46, for the full text
of the letter.*

Consultation Event

June 29, 2016, in Spokane, WA, in
conjunction with the National Congress
of American Indians' Mid-Year
Conference.

In the second consultation topic of 2016, VA asked tribes to identify their top three to five priorities for serving Veterans in Indian Country.

The goal for gathering these priorities is to keep VA informed on an ongoing basis about the needs that tribal governments face when serving Veterans, especially needs that may be unique to Indian Country and tribal communities. Tribal government priorities can inform VA as it identifies needs among Veteran populations, makes decisions about how to deliver services and benefits, and considers how best to fulfill its mission among American Indian and Alaska Native Veterans.

To facilitate this consultation, VA created a fact sheet describing current areas of programming and focus that VA has for serving American Indian and Alaska Native Veterans. The fact sheet gave information on the current status and activities of these programs and asked respondents to name priorities for serving Veterans, either by choosing among the programs named or by identifying other priorities or needs not addressed on the fact sheet.

Consultation Event

This consultation was supported by the release of a Dear Tribal Leader letter on May 19, 2016, to 567 federally recognized tribal governments, inviting tribes to offer written consultation feedback. (See Appendix C, page 46, for the full text of the letter). It was also supported by a consultation event that took place on June 29, 2016, in Spokane, WA, where testimony from tribal leaders and representatives was received by VA representatives.

To reach the widest possible audience of tribal leaders, the consultation event was scheduled in conjunction with the National Congress of American Indians' Mid-Year Conference.

The consultation event was facilitated by:

- **James Albino**, Deputy Assistant Secretary for Intergovernmental Affairs, and
- **Stephanie E. Birdwell**, Director, Office of Tribal Government Relations.

The following officials represented VA and its administrations and departments, as well as its regional and local units for the Spokane, WA, event:

- **Michael J. Murphy**, Interim Director, VA Northwest Health Network;
- **J. Ronald (Ron) Johnson**, Director, Mann-Grandstaff (Spokane) VA Medical Center;
- **Pritz Navaratnasingam**, Director, Seattle Regional Benefit Office, Veterans Benefits Administration;
- **Allegra Long**, Relationship Manager, Pacific District Veterans Experience Office; and
- **Majed Ibrahim**, IHS/Tribal Health Program Reimbursement Agreements Program Manager, Chief Business Office, Veterans Health Administration.

Representatives from related organizations also joined the panel:

- **Christopher Mandregan, Jr.**, Acting Deputy Director, IHS, and
- **Alfie Alvarado-Ramos**, Director, Washington State Department of Veterans Affairs.

Consultation Input

This consultation's unique format, where participants named and ranked priorities for Veterans, creates the opportunity for analysis of consultation input in a way that is not usually possible in the detailed policy discussions that occur in some consultations.

The consultation input received represents the wide range of stakeholders on Veterans' issues in Indian Country. Input came primarily from tribal leaders of federally recognized tribes, but also from Native Veterans, stakeholders who serve and advocate for Native Veterans' needs, national and regional Native health and advocacy organizations, and urban Indian health organizations. There were 71 total responses in this consultation, including written input and priorities discussed in testimony at the consultation event, which came from the following consultation participants:

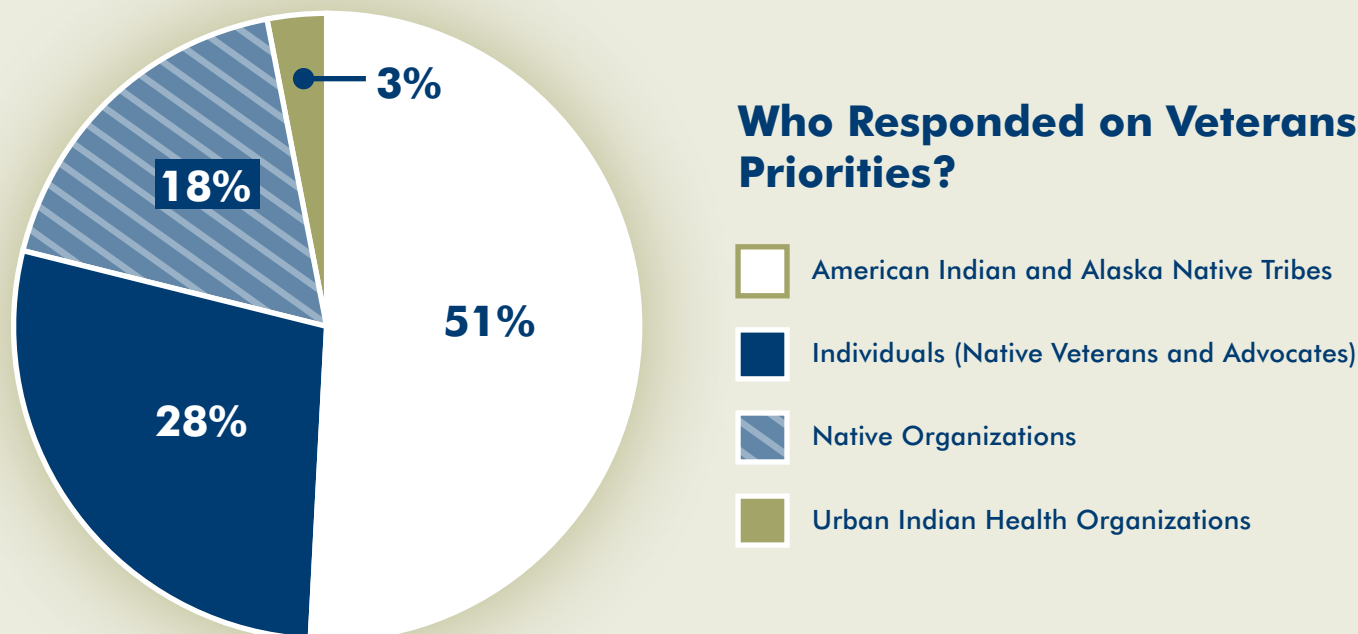
- 36 tribes,
- 20 individuals (Native Veterans and advocates),
- 13 Native organizations, and
- 2 urban Indian health organizations.

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These respondents are shown by percentages in Figure 1.

Figure 1. Consultation Respondents



To understand the scope of the input gathered for this consultation, it is important to understand the role of regional and national Native organizations. Some Native organizations who gave input in this consultation included:

- **National Indian Health Board**, representing all federally recognized tribes and the 12 regional Indian Health Boards that represent each IHS area;
- **National Council on Urban Indian Health**, representing 34 federally funded urban Indian health organizations nationwide that serve the majority (70 percent) of the American Indian and Alaska Native population who live in urban areas; and
- **Alaska Native Tribal Health Consortium**, representing all tribal health care systems in Alaska and serving the 229 federally recognized tribes of Alaska.

Taken together, the input of Native organizations (especially national Native organizations) on this consultation represents input on behalf of all 567 federally recognized tribes, indicating the wide range of responses received. The priorities identified and prioritized through tribal consultation are discussed in detail in a special section beginning on page 8.



Brenda McEwing (left) and Julia Kelly

First Nation Women Warriors, Native American Indian Veterans,
and Iraqi War Veterans

Top Priorities for Veterans in Indian Country

Based on consultation input, the majority of priorities identified for Veterans fell within the current programs undertaken by VA for Native Veterans, showing that VA's current activities have a high degree of alignment with the needs and priorities identified by tribes. However, consultation input did include other priorities identified by tribal leaders that were not part of VA's list of current efforts, suggesting needs in tribal communities and among Native Veterans that VA should investigate.

VA asked tribes to identify their top priorities from among current VA priorities, some of which are specifically related to AI/AN tribal governments and tribal Veterans. During tribal consultation on this subject, tribes identified several additional priorities. The Other Priorities section below describes the additional priorities that were gathered through tribal consultation and explains why they are important to tribal governments.

What Priorities Were Identified?

All priorities for serving Veterans in Indian Country include the following.

71 responses from tribes, Native organizations, urban organizations, and individuals (Native Veterans and advocates) identified **23 priorities** for Veterans in Indian Country.

13 priorities were part of VA's current programming.

All 13 current VA programs and initiatives for Native Veterans were ranked as priorities in consultation input.

10 other priorities were identified by tribes.

Current VA Priorities Supported by Tribes



Access to Medical Care



Treatment for Post-Traumatic Stress Disorder (PTSD) and Mental Health



Benefits for Families



Tribal Consultation and Listening Sessions



Employment/
Vocational
Rehabilitation



Tribal Veterans
Representatives



Homelessness



Understanding Benefits



Housing



VA and IHS or Tribal
Facilities Working Together



Suicide Prevention



VA Supporting Traditional
Providers/Treatments



Transportation



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Other Priorities Identified by Tribes

- Care in the Community – VA's Consolidated Care Plan
- Dental Care
- Including Urban Indians and Urban Indian Organizations
- Increasing VA's Cultural Sensitivity
- Nursing Care for Veterans
- Substance Abuse Treatment
- Tribal Veterans Advisory Committee
- Tribal Veterans Cemeteries
- VA Outreach to Tribal Communities
- Veterans Status

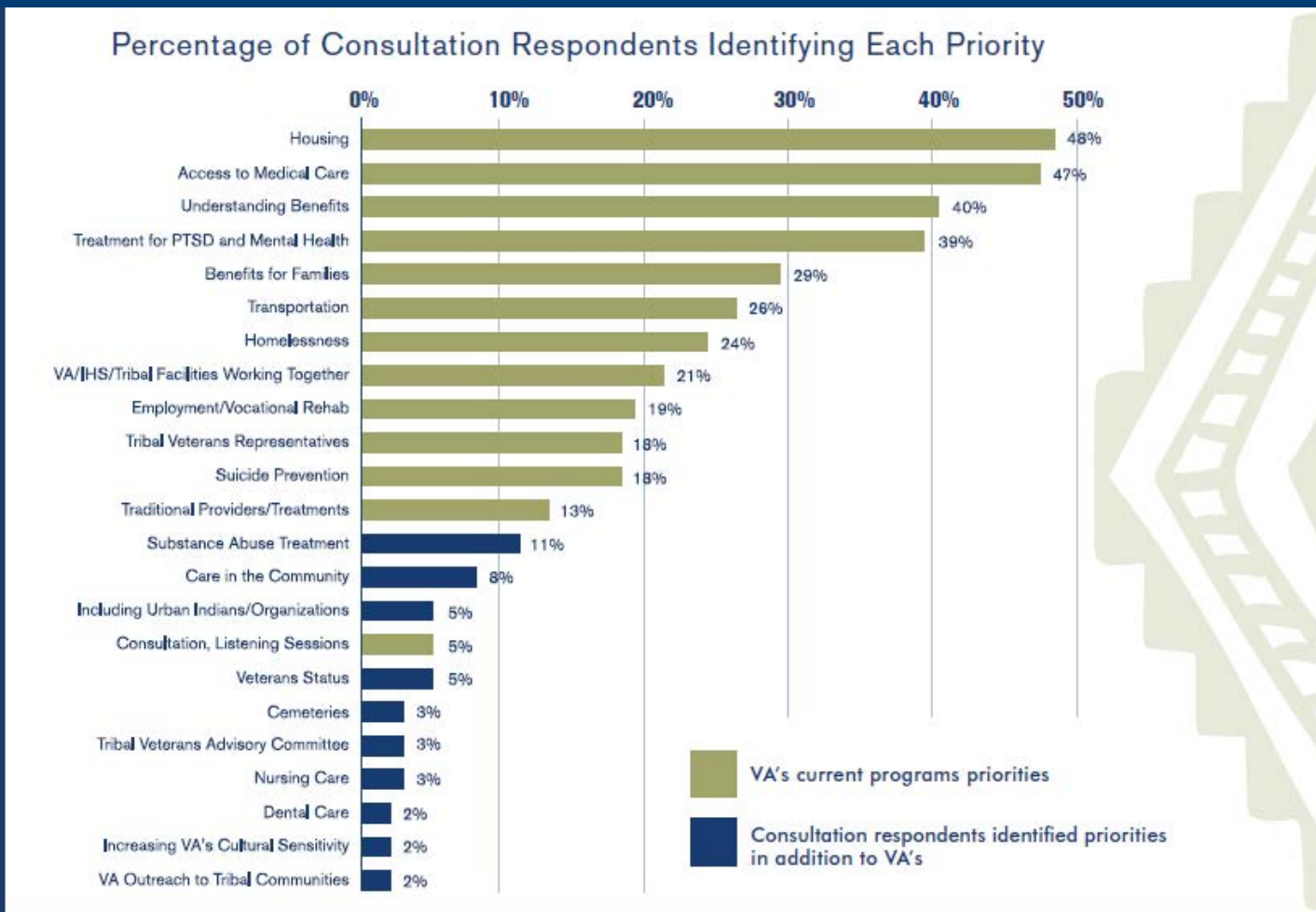
Figure 2 and Figure 3 examine tribes' top priorities for serving Veterans. Within both charts, current VA priorities supported by tribes are shown in green. Additional priorities identified by tribes through the consultation process are shown in blue.



Native American Indian Veterans prepare for the Formal Grand Entry ceremony during the Second Annual National Gathering of American Indian Veterans.

Figure 2 shows which priorities were identified the most frequently by consultation respondents. Priorities already included in VA's list of current programs are shown in green, and priorities identified by consultation respondents in addition to VA's list of priorities are shown in blue. This graph focuses on how often a priority was named and does not include whether or not any particular priority was ranked more highly than another.

Figure 2. Percentage of Consultation Respondents Identifying Each Priority

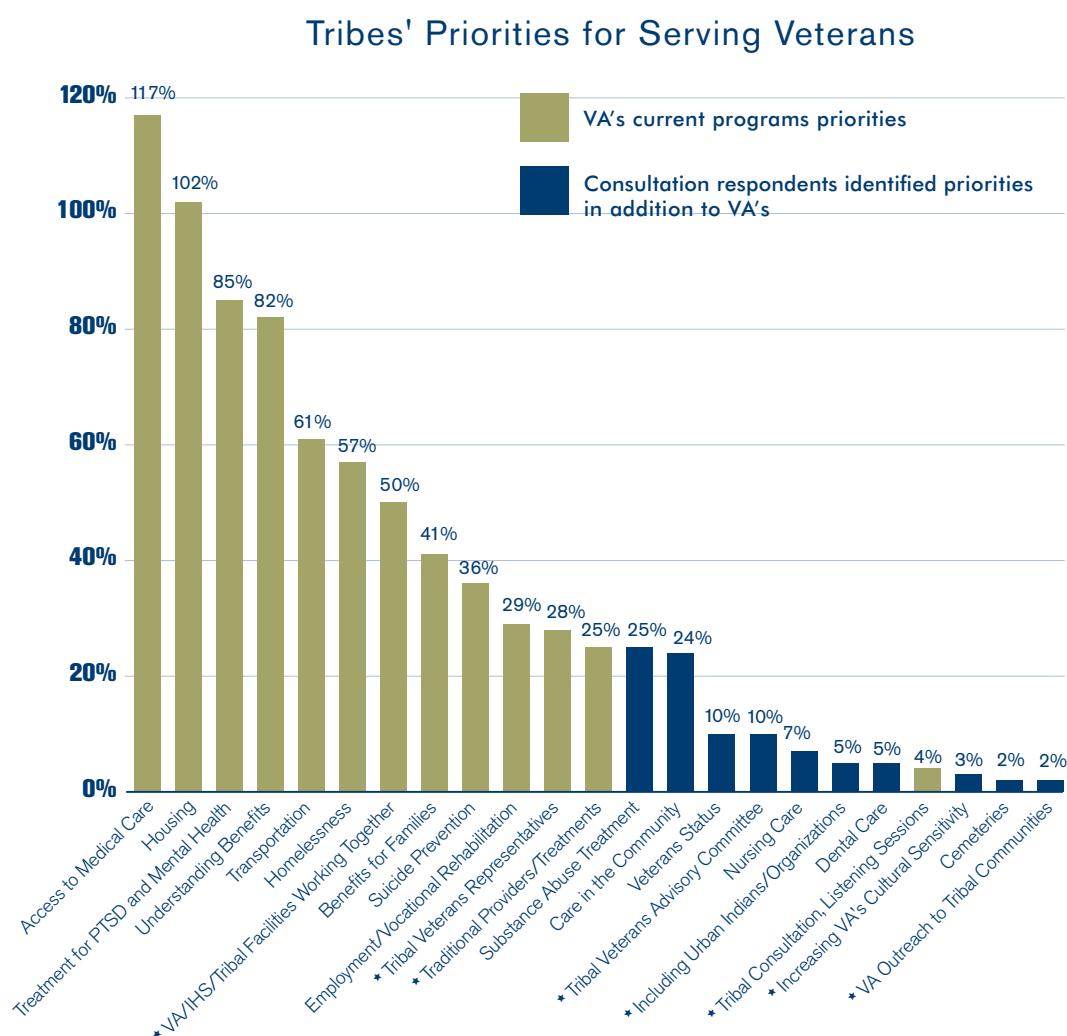


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Figure 3 shows how these priorities were ranked. In ranking their priority issues from 1 through 5, consultation respondents gave information about which issues they thought were the most important, relative to other issues. Although ordering the list by ranking does not change the order significantly, it does reveal that **access to health care** was most consistently ranked as the highest priority among consultation respondents. Starred priorities are culturally specific items relevant to AI/AN tribal governments and Veterans.

Figure 3. Ranks Awarded to Each Priority



Based on comparing both lists and combining topics that are closely related, OTGR identified the following priorities for serving Veterans in Indian Country, as expressed by consultation participants in 2016.

Top Priorities for Serving Veterans in Indian Country

1. Access to health care
2. Addressing housing and homelessness
3. Treatment for PTSD and mental health
4. Understanding benefits, including benefits for families
5. Transportation

Other Priorities

In consultation feedback that OTGR collected, some responses included priorities that were not already identified in the list of VA's current programs and priorities for Veterans in Indian Country. This section discusses these priorities, providing additional information on what they include and why they are important to tribal governments. These other priorities are listed in the order of the frequency and rank with which they were identified in consultation responses.

Substance abuse treatment – Many tribal representatives mentioned the importance of substance abuse treatment resources for Veterans in Indian Country. Of all other priorities identified, this one was identified with the most frequency. Several respondents identified it as their highest priority.

Care in the Community: VA's Consolidated Care Plan – Tribal representatives named the outcomes of VA's Plan to Consolidate Care in the Community as an important issue in their priorities for serving Veterans. Some tribes and organizations, including multiple organizations representing tribes and Native health organizations across the state of Alaska, named the continuation of tribal reimbursement agreements as their highest priority in this consultation. Other tribes indicated the need for assistance in finalizing tribal reimbursement agreements that were currently in process.

*For further discussion of tribal responses to VA's Plan to Consolidate Care in the Community, see **Consultation 3: Care in the Community**, on page 17.*



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Southcentral Foundation's top three to five priorities can be encapsulated as one: ensuring that the VA and tribal facilities continue to work together by extending the Alaska Sharing and Reimbursement Agreements for at least an additional 5 years.

—Southcentral Foundation (Alaska)

Including urban Indians and urban Indian organizations – Of the three sectors making up the Indian health system—IHS facilities, tribally operated health care facilities, and urban Indian health organizations—urban Indian organizations are the fewest in number and, often, are not explicitly addressed in health policy or programs. Tribal consultation respondents recommended that urban Indian health organizations be represented at tribal consultations and be able to enter into reimbursement agreements with VA.

Veterans status – Some representatives listed determining and changing Veterans' statuses, including their benefit, disability, and discharge status, as a priority. They reported that Native Veterans with other-than-honorable discharges need assistance in changing their discharge status, and Veterans living in remote locations (such as Alaska Native villages) need a way to stay informed about changes in their Veteran status.

Tribal Veterans cemeteries – Some tribes requested assistance in accessing VA's Veterans Cemetery Grants Program through the National Cemetery Administration, which offers grants for tribal governments to establish cemeteries on tribal trust lands.

A tribal Veterans advisory health care committee – Two national Indian organizations, the National Indian Health Board and the National Council on Urban Indian Health, strongly recommended the creation of a tribal Veterans advisory committee on health care. These organizations pointed out that such an advisory committee would follow the model already in use by most agencies within the Department of Health and Human Services, where tribal advisory committees at the agency level are common.

Finally, a small number of consultation respondents mentioned these priorities in serving Veterans:

- Nursing home care and benefits,
- Dental care,
- Increasing VA's cultural sensitivity, and
- Ongoing VA outreach to tribal communities.

VA Consultation and Program Updates

Based on 2016 consultation efforts, VA's Office of Tribal Government Relations has used tribal input to identify the highest shared priorities that American Indian and Alaska Native tribal governments hold for serving Veterans in Indian Country. OTGR has also gained valuable input on the wide range of concerns that tribal governments have when addressing their Veterans' needs. OTGR will share the identified priorities with tribal governments, with Native Veterans organizations, and with other stakeholders. OTGR will also use these priorities to inform VA's administrations and Congress on an ongoing basis about issues that are most important for tribes and for Veterans in Indian Country.

VA works on an ongoing basis to address the needs of Veterans in Indian Country and to advance the current VA programs and priorities that continue to serve Native Veterans and tribal nations.

The Veterans Health Administration, which manages VA's health care activities across the Nation, reported the following accomplishments in 2016 regarding reimbursements between VA, IHS, and tribally operated health programs.

- **99 total reimbursements agreements** have been signed between tribally operated health programs and local VA medical centers, with 10 new agreements finalized in 2016.
- **83 implementation plans** covering 105 IHS sites are active as of 2016. These implementation plans operationalize the processes of VA reimbursement for IHS health facilities.
- **\$17.4 million total in VA reimbursements** were issued to IHS and tribal health programs in 2016.

The National Cemetery Administration administers the Veterans Cemetery Grants Program. This program offers grants for tribal governments to establish, expand, and improve cemeteries on tribal trust lands as well as grants for operation and maintenance of such cemeteries. The National Cemetery Administration reported that four new tribal Veterans cemeteries were dedicated or opened in 2016:

- **San Carlos Apache Veterans Cemetery** in San Carlos, AZ;
- **Big Sandy Rancheria Band of Western Mono Indians Veterans Memorial Cemetery** in Auberry, CA;
- **Apsaalooke Veterans Park (Crow Nation)** in Crow Agency, MT; and
- **White Eagle Cemetery (Ponca Tribe)** in Kay County, OK.

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Including these four newest cemeteries, there are now **nine tribal Veterans cemeteries fully operational on tribal lands**, which have received funding through the National Cemetery Administration's grant program.

The Native American Direct Loan (NADL) program, administered by the Veterans Benefits Administration, assists eligible Native Veterans in financing, buying, or improving homes on tribal lands by providing loans with no downpayment and low closing costs. Before VA can make a loan to a Veteran, VA and the respective tribal government must sign an MOU. As of 2016, there are **97 total NADL MOUs** between tribes and VA, with four new MOUs finalized during 2016.

VA continues outreach for all of these programs at regional and local levels so tribes and Veterans can learn about the benefits and programs that may be available to them.



Mr. Saginaw Grant (center), Mr. Norman Shay (right), Mr. Joe Yazzie (left)

Native American Indian Veterans perform opening festivities, including "First Pitch" and Color Guard ceremony, complete with Eagle Sticks, during the Second Annual National Gathering of American Indian Veterans held at Cantigny Park in Wheaton, Illinois, on August 19-21, 2016.

Consultation 3: Care in the Community

In the third consultation topic of 2016, VA asked tribes for input on questions related to consolidating health care provided to Veterans through non-VA health facilities into a standard system. This vision for consolidation was described in VA's *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, which was drafted by the Veterans Health Administration. The plan was required by the VA Budget and Choice Improvement Act, section 4002, and was submitted to Congress in October 2015.

The goal for this consultation was to seek tribal input about the possible impacts of proposed consolidation measures that would assist VA in developing a more standardized and consolidated health care network. VA asked tribes to comment specifically on the following issues:

- Transitioning from the current reimbursement structure (based on reimbursement agreements between VA and IHS and tribal health programs) to a standard arrangement for reimbursement managed by a third-party administrator for VA;
- Expanding direct care services under this new structure, to include reimbursements for care provided to Veterans enrolled in VA health care, whether or not they are eligible for IHS or tribal health care;

Consultation 3 Topic and Questions

- Consolidation of non-VA care, including:
 - ◇ Standardized reimbursement structure;
 - ◇ Serving non-Native Veterans;
 - ◇ Reimbursement rates; and
 - ◇ Extension of existing reimbursement agreements.

Consultation Period

September 12, 2016 – November 30, 2016

Dear Tribal Leader Letter

Released September 12, 2016.

See Appendix C, page 46, for the full text of the letter.

Consultation Event

September 28, 2016, in Washington, DC, in conjunction with White House Tribal Nations Conference.

- Receiving standardized reimbursements based on a Medicare plus a feasible percentage rate within a new consolidated system; and
- Extending any new and existing reimbursement agreements between VA and tribal health programs through December 2018, as VA works to implement a consolidated care program.

Consultation input from tribes and Native organizations is listed in **Consultation Questions and Answers on page 20**, and grouped according to these four issues.

2015 Consultation as Background: Including IHS/Tribal Providers in VA's Core Provider Network

In 2015, VA conducted consultation with tribal governments on questions related to the proposed transition to a consolidated system.

As it prepared to submit its plan to consolidate community care, required by the VA Budget and Choice Improvement Act, section 4002, VA proposed to refer to IHS and tribally operated health programs as members of VA's core provider network. In VA's plan for community care, inclusion in the core provider network would preserve and build on VA's existing relationships with IHS and tribal health providers and facilitate future collaboration to improve health care services provided to all eligible, enrolled Veterans. The 2015 tribal consultation asked for input from tribes on the proposed inclusion of IHS and tribal health care facilities in VA's core provider network, as well as VA's efforts to streamline the provision of non-VA care to Veterans.

VA requested tribal input in two consultation letters, and the final comment period closed on October 26, 2015. Feedback from tribes who responded to this consultation opportunity included:

- Strong support for including IHS facilities and tribal health programs as key partners in VA's community network;
- A desire to maintain and strengthen current agreements VA has with IHS and tribal health programs; and
- Interest from IHS and tribal health programs to potentially serve non-Native Veterans.

Tribal input received during this consultation was used to inform the plan to consolidate community care that VA submitted to Congress on October 30, 2015. Consultation in 2016 continued the discussion about how VA will shape and structure its core provider network and other non-VA care to deliver care to Veterans, and how IHS and tribal health care facilities will be incorporated.

Consultation Event

The 2016 consultation on care in the community was supported by the release of a Dear Tribal Leader letter on September 12, 2016, which invited tribes to submit written input and attend an in-person consultation event. (See Appendix D, page 50, for full text of the letter). The consultation event took place on September 28, 2016, at the National Museum of the American Indian in Washington, DC, scheduled in conjunction with the White House Tribal Nations Conference, which took place on September 26 and 27, 2016.

The consultation event was facilitated by:

- **James Albino**, Deputy Assistant Secretary for Intergovernmental Affairs, and
- **Stephanie E. Birdwell**, Director, Office of Tribal Government Relations.

The following officials represented VA and its departments, particularly the Veterans Health Administration, which authored the plan for consolidated care:

- **Dr. Richard Stone**, Principal Deputy Under Secretary for Health;
- **Dr. Baligh Yehia**, Assistant Deputy Under Secretary for Health, Community Care, Veterans Health Administration; and
- **Majed Ibrahim**, IHS/Tribal Health Program Reimbursement Agreements Program Manager, Chief Business Office, Veterans Health Administration.

Consultation Input

Of the topics in 2016, consultation on care in the community gathered the most detailed policy input on VA's proposed care strategies. This report summarizes that input, so that VA has a record of the concerns and input shared by tribes as it continues to develop and refine its care in the community proposal.

Including written testimony and testimony at the in-person event, consultation input was received from:

- 30 tribes and tribal and urban health organizations and
- 9 national and regional Native organizations.

The nine regional and national Native organizations that gave consultation input represented tribes across the nation. There are 567 federally recognized tribes, and some tribes were represented by more than one organization. National Indian organizations with broad membership and representation who gave consultation input included, but were not limited to:

- **National Indian Health Board**, representing the health interests of all tribal governments, including those that operate their own health care systems and those served by IHS;

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- **National Council on Urban Indian Health**, representing 34 federally funded urban Indian health organizations nationwide that serve 70 percent of the American Indian and Alaska Native population that live in urban areas (areas that are not on reservations);
- **Tribal Self Governance Committee**, representing 360 self-governance tribes (tribes that are contracted with IHS to operate their own health programs); and
- **Alaska Native Health Board**, representing all 229 federally recognized tribes in the state of Alaska.

Consultation Questions and Answers

Based on the four questions from VA in the Dear Tribal Leader letter (included as Appendix D, page 50) for this consultation topic, input from tribal and Native organizations is listed below.

Question 1: Standardizing Reimbursement Structure, with Third-Party Administrator

What would be the impact of transitioning from the existing reimbursement agreement structure, which requires each tribe to enter into an individual reimbursement agreement with VA, to a standard arrangement for reimbursement of direct care services provided to eligible Veterans managed by a third-party administrator for VA?

Summary of Tribal Responses to Question 1

All tribes and organizations that responded uniformly expressed that they do not support transitioning to a standardized agreement for reimbursement. The main reasons tribes oppose this change are because it groups American Indian and Alaska tribes with VA vendors and other businesses, instead of respecting tribes' unique relationship with the Federal Government. This relationship includes the federal trust responsibility and the government-to-government relationship, both of which substantially predate the Choice Act. Tribes prefer the current Memorandum of Understanding Between the Department of Veterans Affairs (VA) and Indian Health Service (IHS) (VA-IHS MOU) and the IHS and tribal health program reimbursement agreements to the proposed consolidation and argue that the VA-IHS MOU and IHS/tribal reimbursement agreements should be fully implemented, extended, and improved as the best strategy to address VA's health care delivery goals. No tribal respondents indicated support for the proposed consolidation. When tribes addressed a possible consolidation, it was to enumerate concerns they anticipated with its implementation.

Standardized Reimbursement Structure

Tribes stated that they are not vendors, and a standardized agreement that consolidates tribes with other VA vendors is not acceptable.

A standard agreement developed by a third-party administrator would not reflect tribes' government-to-government relationship with VA and with the Federal Government. IHS and tribal health programs are not a procurement source. They are federally funded programs

carrying out federal responsibilities alongside VA. The federal trust responsibility that VA has toward tribes, and the authorization of sharing arrangements through the Indian Health Care and Improvement Act of 2010, are distinct from and supersede the Choice Act.

As Secretary McDonald expressed so eloquently when he met with tribes in Alaska [in 2015], it makes no sense for VA to pay a vendor to manage VA's relationships with governmental partners, including Indian health providers. Introducing a vendor into the mix as a go-between merely complicates the referral process for the Veteran, the local Veterans Health Administration programs, and the Indian health programs.

—Alaska Native Tribal Health Consortium

Tribes reminded VA that the U.S. Federal Government has a trust responsibility to provide health care to tribal nations and to American Indian and Alaska Native citizens based on the treaties signed between the U.S. Government and tribes.

The United States has a trust obligation to provide health care to all American Indian and Alaska Native citizens, which has been recognized through treaties, statutes, executive orders, and Supreme Court case law. This trust obligation extends to the entire Federal Government, including VA, which is a critical component of the Federal Government's trust responsibility to provide health care to Native Veteran patients. Many tribes explained how decreases in services, resulting from any decreases in reimbursement rates or access to care, would violate the Federal Government's trust responsibility. Some tribes argued that a breach in the current reimbursement agreements would be a failure of the Federal Government to provide treaty-secured health care to Native Veterans.

Tribes reminded VA that VA's Secretary committed to maintain a direct government-to-government relationship with tribes when he addressed Alaska tribes in 2015.

In August 2015, VA Secretary Robert McDonald visited Alaska and addressed the Alaska Native Health Board Mega Meeting, recognizing the sovereign status of tribes and committing to a government-to-government relationship in line with President Obama's 2009 memorandum on tribal consultation. The Secretary said he viewed VA's relationship with tribes as having "favored status," in line with working with other arms of the government, such as the Departments of Defense and Health and Human Services. The Secretary explained that it makes no sense for VA to pay a vendor to manage VA's relationships with governmental partners, including Indian health providers. Introducing a vendor into the mix as a go-between merely complicates the referral process for Veterans, local Veterans Health Administration programs, and Indian health programs.

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In August 2015, Secretary McDonald recognized the sovereign status of tribes and committed to a government-to-government relationship in line with President Obama's efforts. He shared he viewed the Department of Veteran Affairs' relationship with tribes as having "favored status," in line as working with other arms of the government, such as the Department of Defense and the Department of Health and Human Services. Tribes assert that we are not vendors, and thusly, should not be categorized as part of the Community Care program.

—Alaska Native Health Board

Tribes referenced the consolidation plan that the Veterans Health Administration submitted to Congress, which stated that VA will honor its current relationship with federal partners, including IHS and tribal health programs.

In October 30, 2015, VA reported to Congress on its "Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care" as part of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. In this report, VA stated its intent to "...honor VA's special relationships with strategic partners, such as DoD [the Department of Defense], IHS, THP [tribal health programs], FQHC [federally qualified health centers] ..." in its efforts to implement a new purchased care strategy. Going further, the report explicitly identified IHS and tribal health programs, explaining that "VA will continue to use established payment mechanisms with DoD, IHS, THP, FQHC, and academic teaching affiliates while at the same time moving toward paying Medicare rates for commercial partners." Tribes said they agree with these recommendations and asked why VA contravened its commitment to IHS, tribal health programs, and its own plan that it submitted to Congress.

Tribes are concerned about the problems they anticipate under a third-party-administered VA system, and they believe that the terms of new agreements would be unfavorable compared to current reimbursement agreements.

Tribes anticipate the following undesirable consequences of a consolidation:

- Services would require pre-authorizations, interrupting continuity of care and causing delays.
- Native Veterans would be expected to pay copays, which is unacceptable given the federal trust responsibility.
- A third-party administrator would add a layer of costly bureaucracy between VA and tribal health programs.

- Reimbursement rates to tribal health programs would decrease.
- The third-party administrator would not be knowledgeable about the Indian health system.
- A new system might be like the military's Tricare, which has delays, poor customer service, and highly stringent reimbursement requirements.
- IHS and tribal health programs would need to re-learn a new process for billing, creating administrative challenges and costs.

Tribes said that individual agreements between tribes and VA are necessary, instead of one consolidated agreement.

Each tribe has its own government-to-government relationship with VA and is entitled to negotiate its own terms that best meet the needs of its Veterans. Common language, or an agreement template, could be provided as a starting place for negotiations. Tribal consultation would be a critical element of developing such a common template.

Tribes expressed a belief that consolidating reimbursement agreements under a standardized VA plan would also nullify the current VA-IHS MOU, and conveyed that changes to the MOU are undesirable.

Tribes indicated that, instead of consolidating reimbursement agreements under VA, the VA-IHS MOU should be continued and fully implemented. Consolidation would cause the loss of the MOU's many provisions for collaboration and resource sharing between VA and IHS, including cooperation on staffing, facilities, and tribal access to the Consolidated Mail Order Pharmacy.

Tribes explained that current reimbursement agreements provide unique values and benefits that would not be captured by a consolidated plan.

The current reimbursement agreements provide access to care for AI/AN Veterans close to home in rural areas. They ensure that AI/AN Veterans have access to culturally sensitive care. Several tribes identified keeping in place the VA-IHS MOU and the related reimbursement agreements between tribal health programs and IHS as their highest priority for serving Veterans in Indian Country. Tribes recommended that the VA-IHS MOU model be used as a foundation for implementing services under the Choice Act because of its current successes.

Tribes requested further consultation if the consolidated plan moves forward.

Tribes reminded VA that, if a future consolidation agreement is developed, it needs to be communicated clearly to tribes. VA should provide opportunities for consultation to ensure tribal input and feedback is included.

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VA provides the following response on a standardized reimbursement structure.

At this time, VA will maintain a direct relationship with tribes and IHS through the current reimbursement agreement structure. Without changing any significant terms, VA proposes to amend all existing agreements to reflect a new expiration date of June 30, 2019. Meanwhile, VA will work closely with tribal health programs, through consultation and other collaborative activities with tribes, to ensure that VA's consolidated community care program allows for the continuation and growth of the unique relationship that tribal health programs have with VA and Veterans.

VA has the responsibility of paying for care provided to eligible Native and non-Native Veterans in a manner that is fair, reasonable, and properly reflects the services provided. Between now and June 30, 2019, VA would like to work with tribes to consider how some of the agreements' terms, such as the rate structure, could be changed in future agreements to reflect a more recent industry-standard, value-based structure that benefits the Veterans who receive care.

Third-Party Administration

Tribes recommended that third-party administration of a standardized VA system, if it occurs, needs careful oversight and monitoring.

Tribes indicated that VA must ensure respectable reimbursement timelines, acceptable processing guidelines, and tribal customer service representatives.

VA provided the following response on third-party administration.

At this time, VA will not employ a third-party entity to administer the reimbursement process between VA and tribes. Instead, VA will continue to maintain a direct relationship with tribes through reimbursement agreements. VA will also continue to process claims received from tribes in a timely manner, within 30 days from the receipt and approval of the claim.

Support for the VA-IHS MOU

Tribes believe that consolidating reimbursement agreements under a standardized VA plan would also nullify the current VA-IHS MOU, and that changes to the MOU are undesirable.

Instead of consolidating reimbursement agreements under VA, the VA-IHS MOU should be continued and should be implemented fully. Consolidation would cause the loss of the many provisions for collaboration and resource sharing between VA and IHS in the MOU, including cooperation on staffing, facilities, and tribal access to the Consolidated Mail Order Pharmacy.

We do not support or recommend that tribal [reimbursement] agreements be standardized to incorporate Choice Act provisions because the current agreements are successful in providing additional care to AI/ANs and respect the government-to-government relationship.

—Tribal Self Governance Advisory Committee

VA provided the following response on the VA-IHS MOU.

Activities under the reimbursement agreements fall under only one provision of the larger 2010 VA-IHS MOU. Efforts related to the reimbursement agreements would not affect the ongoing implementation of other elements of the MOU. At this time, VA will maintain its direct relationship with IHS and tribes through the current reimbursement agreements structure. Along with tribal health program reimbursement agreements, the Agreement Between the Department of Veterans Affairs Veterans Health Administration and Department of Health and Human Services Indian Health Service for Reimbursement for Direct Health Care Services (VHA-IHS Reimbursement Agreement) has been amended to reflect a new expiration date of June 30, 2019.

Meanwhile, VA will work closely with IHS and tribes to enhance the reimbursement agreement for the benefit of Veterans.

Expansion and Improvement of Current Agreements

Tribes noted that the current reimbursement agreement model has great capacity to be extended to other tribes.

Tribes expressed a belief that too few reimbursement agreements have been finalized, suggesting there is much more capacity to improve access to care for Veterans, especially in remote and rural locations.

Tribes argued that current reimbursement agreements can be improved by streamlining the process to create and approve them.

Some tribes reported waiting multiple years for reimbursement agreements to be finalized and wanted to see improvements to this timeline.

Tribes said that the coordination of care between VA and IHS under the VA-IHS MOU and current reimbursement agreements still needs improvement.

Tribes explained that VA does not reimburse IHS purchased and referred care or tribal health program referred care, and that Veterans must receive multiple referrals for the same health need.

VA provided the following response on expanding and improving current agreements.

VA currently has 99 reimbursement agreements in place and is actively seeking additional agreements with interested tribes. In coordination with IHS and OTGR, the VA team that oversees IHS and tribal health program reimbursement agreements continues to conduct multiple outreach activities to increase the number of agreements.

The average time to establish a reimbursement agreement is about 3 months from the time the tribe attends the initial orientation call. However, this time varies and may extend to years if tribes are interested in changing the terms of the established agreement template or if site readiness documentation is not completed and submitted in a timely manner. In a few cases, VA was not able to execute agreements with tribes because of the changes the tribes asked for. The tribal health program reimbursement agreement template is based on the VA-IHS Reimbursement Agreement, which has been reviewed for compliance with appropriate legal authorities. Significant deviations from the template result in additional reviews for statutory and regulatory compliance, which causes delays and may ultimately be outside the authority or scope of these specific agreements.

VA acknowledges that current reimbursement agreements cover direct care services and exclude referred care services. Moving forward, VA will work with IHS and tribal health programs to explore the possibility of properly and feasibly including referred care in reimbursement agreements.

Question 2: Serving Non-Native Veterans

Would tribal health programs be interested in expanding direct care services under this new structure to include reimbursements for care provided to all Veterans enrolled in VA health care, regardless of whether they are eligible for IHS-funded health care or not?

Summary of Tribal Responses to Question 2

Most tribes responded that they would be interested in expanding services to non-Native Veterans, providing that the reimbursement rate for services remains the same as that for Native Veterans. These tribes also clarified that as a general rule that serving non-Native Veterans must be adopted at the choice of each tribe and could not be dictated by an outside source. Tribes in Alaska are already serving non-Native Veterans under their current statewide reimbursement agreements, and they reported that this is a successful arrangement. A small number of tribes reported that they were not interested in serving non-Native Veterans or that serving non-Native Veterans was specifically unallowable under their tribal health program.

Serving Non-Native Veterans

Tribes already have the authority to serve non-Native patients in tribal health facilities, and this change is desirable.

Under existing policy, including Section 813 of the Indian Health Care Improvement Act, tribes and tribal organizations may elect, but are not required to provide health care services to non-IHS beneficiaries. This existing authority is the least administratively burdensome way to extend care to non-Native Veterans living in remote areas served by tribal health programs.

Alaska tribes are already successfully serving non-Native Veterans.

Alaska tribes currently serve 6,500 non-Native Veterans in their tribal health system, and they report that their referral and approval system for serving non-Native Veterans could be easily exportable to other areas. In the Alaska system, non-Native Veterans are seen by tribal health programs when they are referred to a tribal health facility by VA, often because nearby VA facilities lack the capacity to serve their medical needs or when they live more than 40 miles away from a VA health facility.

We serve a large non-Native population [already], particularly in our rural communities where we're the only [health care] provider ... it's a very sophisticated system ... [and] the Alaska tribal sharing agreement actually became the model for the Choice program.

—Norton Sound Health Corporation (Alaska)

Tribes that agree to serve non-Native Veterans should have choice and flexibility around how to implement this change.

Tribes that agree to expand care to non-Native Veterans recommend that the impact be continuously monitored to ensure that care for IHS-eligible patients does not diminish in quality. Any reimbursement agreement relating to non-IHS Veterans should allow tribes to define what direct care services it can make available.

Tribes argued that reimbursement rates for non-IHS patients should be the same as for Native Veterans.

Tribal health programs should be reimbursed for all VA patients, regardless of whether they qualify for IHS care, and the same rates should be paid for all Veterans. Current cost-based reimbursement is designed to ensure the viability of extending and maintaining access in some of the most remote and rural parts of the United States, and this rate should be maintained.

Some tribes do not plan to see non-IHS-beneficiary patients because of regulations and because it may diminish the quality of care for existing patients.

These tribes explain that providing services to non-eligible patients would be inappropriate, given the unmet needs of their existing eligible patients, or unallowable, because of current service agreements.

VA provided the following response on serving non-Native Veterans.

VA understands that tribes can and do currently elect to provide care to non-Native Veterans at their tribal health facilities. VA particularly acknowledges the success that Alaska tribes have had in serving non-Native Veterans. VA will continue to reimburse Alaska tribal health programs for care provided to non-Native Veterans in Alaska. Without changing any significant terms, including reimbursements for non-Native Veterans, VA proposes to amend the existing reimbursement agreements with Alaska tribes to reflect a new expiration date of June 30, 2019.

For tribal health programs desiring to serve non-Native Veterans, VA will work closely with interested programs to assess their capacity to expand care to non-Native Veterans. Regarding reimbursement rates specifically for non-IHS patients, VA will work with tribes to explore what mechanisms may be available to reimburse care for non-Native Veterans, including the agreement terms, and work to implement a system that is best for Veterans. VA also understands that expanding care to non-Native Veterans is a choice on the part of each tribal health program, and that not all programs are able to provide care to non-Native Veterans. For tribes or programs where interest exists in expanding care to non-Native Veterans, VA will explore with the health programs what mechanisms may be available to achieve it. VA will work with individual tribes to determine what is appropriate before any action is taken.

Question 3: Standardizing Reimbursement Rates

Would tribal health programs be interested in receiving standard reimbursement rates based on Medicare rates, plus a feasible percentage of those rates that minimize improper payments and comply with industry standards?

Summary of Tribal Responses to Question 3

Tribes uniformly reject the proposal to be reimbursed at a standard Medicare-plus rate, because current reimbursement agreements are based on the rate set by the Office of Management and Budget (OMB), a rate that is used throughout the Indian health system. The OMB rate is a higher, encounter-based rate that more accurately estimates the costs

of delivering health care within the rural and remote locations of the Indian health system. Tribes argue that VA provides a critical resource stream for IHS/tribal health program facilities, and that a reduction in reimbursement rates would result in a direct decrease in the quality of care available to Veterans. Tribes also strongly recommend that purchased and referred care (along with direct care services) be reimbursed by VA to fully implement the directive in the Indian Health Care Improvement Act that IHS/tribal health programs are always the payers of last resort.

Standardizing Reimbursement Rates

Tribes do not approve switching away from the OMB rate to a Medicare-plus rate.

The Indian health system, because of its uniqueness, uses the encounter rate established by OMB. When the prospective payment system was developed for Medicare and Medicaid, the Indian health system was exempted from it and continues to use the encounter rate. The rate is established based on the costs for the facility, infrastructure, and provision of care in the Indian health system. This rate is established similarly to how federally qualified health centers establish their rates. Nothing about the encounter rate is improper or out of line with established industry standards.

[National Indian Health Board] strongly opposes the standard rate and any reduction in the rate because of the circumstances that AI/ANs face with regards to physical health and social determinants of health. Any reduction in reimbursement will further exacerbate the conditions that the Indian Health System faces.

—National Indian Health Board

Tribes explained that any decrease in reimbursements to IHS/tribal health program facilities will exacerbate current resource shortages in the Indian health system and ration care for Veterans.

Reductions in payments to IHS/tribal health program facilities will reduce the number of services available to Native Veterans, which will diminish access to quality care and widen existing health disparities. IHS and tribal health programs are only funded at around 54 percent of the need, and lower reimbursement rates from VA for more services will further drain their limited health care resources.

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Tribes are concerned that switching to a new rate will incur administrative costs for tribes and for VA. The current VA-IHS MOU and reimbursement rates provide care for the least administrative burden.

Transitioning to a new and separate reimbursement process will require special administration and technical staffing for both tribal and VA staff—not just for billing, but also in setting the feasible percentage and proposed rates for non-Native Veterans. Tribes are concerned that a new agreement would diminish the quality of care and services for Veterans and other IHS/tribal health program patients.

VA reimbursements to IHS/tribal health program providers, even at the higher OMB rate, are a negligible part of VA's budget.

In 2015, VA provided \$33 million in reimbursements to IHS/tribal health program facilities, representing approximately 0.06 percent of VA's entire health budget and 1 percent of the IHS budget. Further, Veterans' health is funded at twice the level per person that IHS is funded. IHS appropriations are currently at approximately \$3,200 per patient, which is far below VA health resources per patient and below the national average for health spending. VA's budget for 200,000 homeless Veterans is equivalent to the total funding for the more than 5 million eligible individuals served by IHS.

VA Responses on Standardizing Reimbursement Rates

VA has the responsibility of paying for care provided to Native and non-Native Veterans in a manner that is fair, reasonable, and properly reflects the services provided, regardless of the total dollar amount reimbursed to IHS and tribal health programs in comparison to the total VA health care budget. To support this responsibility, VA proposes to maintain the current direct relationship with tribes and, without changing any significant terms, amend all existing reimbursement agreements to reflect a new expiration date of June 30, 2019. VA will also work with tribal health programs to ensure that VA's consolidated community care program allows for the continuation and growth of the unique relationship that tribal health programs have with VA and with the Veterans they serve in their communities.

VA will work closely with tribes to revisit some of the terms, including potentially changing the rate structure to a more recent industry-standard, value-based structure that benefits the Veterans who receive care and enhances the quality of that care.

Reimbursements for Purchased and Referred Care

Reimbursements must be expanded to include purchased and referred care.

The current national reimbursement agreement with IHS and, by default, nearly all tribal health program agreements, do not include reimbursements for purchased/referred care. Reimbursement for specialty care provided through purchased and referred care is essential to ensure that Veterans receive the best care possible. Nationally, only 1 in 13 visits is an inpatient visit, but Veterans often need additional services, which cannot be provided directly by IHS/tribal health program providers. Failure to include purchased and referred care in the initial agreement further rations the amount of health care IHS/tribal health programs can provide to Native Veterans and other eligible American Indians and Alaska Natives in the system. It also reflects the fact that Section 405(c) of the Indian Health Care Improvement Act has not been fully implemented. This section specifies that Indian health programs are always the payer of last resort.

Failure to include purchased/referred care in the [reimbursement] agreements further rations the amount of health care IHS and [tribal health programs] can provide to Native Veterans and other eligible American Indians and Alaska Natives in the system.

—Northwest Portland Area Indian Health Board

VA provided the following response on reimbursements for purchased and referred care.

Currently, reimbursement agreements cover direct care services and exclude referred care services. Moving forward, VA will work with IHS and tribal health programs to explore the possibility of properly and feasibly including referred care in reimbursement agreements.

Improper Payments

Tribes are confused and upset as to why VA would imply that tribes have made improper payments.

VA has or can request access to the health records that establish that the care provided by IHS/tribal health program facilities is clinically needed and necessary. VA has not shared any concerns with IHS/tribal health programs about their services or payments.

VA provided the following response on improper payments.

VA did not intend to imply that tribes have intentionally made or would make improper payments. Errors by both VA and tribal health programs may occur unintentionally.

Question 4: Extending Existing Reimbursement Agreements

Would tribal health programs be interested in extending existing reimbursement agreements between VA and tribal health programs through December 2018 and ensuring any new reimbursement agreements between VA and tribal health programs extend through December 2018, as VA works in collaboration with tribes and other VA stakeholders on implementing a consolidated community care program?

Summary of Tribal Responses to Question 4

Tribes agreed that existing reimbursement agreements should be extended, but they did not agree that an extension should be for the purpose of implementing a consolidated program. Many tribes agreed with extending existing agreements through December 2018, but more tribes recommended to extend them for 5 years. Some tribes recommended that the current agreements should be extended indefinitely. While tribes consistently supported extending the agreements, they offered different justifications for the extension, as described below.

Extending Reimbursement Agreements

Tribes recommend to renew existing agreements for 5 years to accommodate tribal health programs' need for stability, continuity, and capacity planning.

The current capacity of IHS/tribal health programs did not occur overnight. It was the product of long-term capacity building. VA reimbursement agreements are part of this capacity and can inform health system development if they are implemented with appropriate timeframes. A renewal timeframe of 5 years is needed to accommodate any kind of transition from current agreements.

Tribes recommend to extend current agreements indefinitely and to create a mechanism that allows automatic renewal. Tribes recommended that reimbursement agreements be extended instead of transitioning to a consolidated system.

VA should extend existing reimbursement agreements through December 2018 at a minimum and work to improve the execution of existing agreements, rather than eliminating them and moving towards consolidation into Community Care. Tribes recommend further discussions and consultation regarding auto-renewals for existing agreements, which would address the delays in finalizing current agreements and allow agreements to be extended indefinitely. Some tribes identified the extension of current reimbursement agreements as their highest priority for serving Veterans in Indian Country.

Some tribes agreed with extending current agreements through December 2018.

Tribes see the benefits of extending the existing reimbursement agreements between VA and tribal health programs through December 2018, at a minimum. VA has not provided any compelling evidence to Congress, IHS, or tribes to discontinue the current agreements.

VA should extend the IHS-VA agreements through December 2018 at a minimum, and work to improve the execution of existing agreements, rather than eliminating and moving towards consolidation into Community Care. If the VA is committed to fulfilling its federal trust responsibility ... strengthening the VA-IHS agreements will be critical to achieving this goal.

—United South and Eastern Tribes

VA provided the following response on extending reimbursement agreements.

VA is proposing to amend its existing agreement to reflect a new expiration date of June 30, 2019. VA is unable to renew existing agreements indefinitely. VA is planning to work closely with IHS and tribal health programs to continue a mutually beneficial relationship beyond that date.

Facilitating Agreements for Additional Collaboration

Tribes recommend that mechanisms allowing agreements to be finalized faster should be implemented, creating an incentive for greater collaboration between VA and IHS/tribal health programs.

Tribes report that it can take years to finalize service expansion agreements between VA and IHS/tribal health program facilities, which could limit incentives to pursue such agreements. For example, in one area, it took 3 years to process an agreement to allow a VA medical center to use a small area in an IHS facility for 2 days per week, in part due to VA's lengthy legal and contracting reviews and the layers of approval required to establish an agreement.

VA provided the following response on facilitating agreements for additional collaborations.

The 2016 consultation is about reimbursement agreements between VA and tribes. The consultation is not related to other types of agreements or memoranda of understanding that tribes may seek to establish with individual VA medical centers. The average time to establish a reimbursement agreement is about 3 months from the time the tribe attends the initial orientation call. However, this time varies and may extend to years if tribes are interested in changing the terms of the established agreement template or if site readiness documentation is not completed and submitted in a timely manner.

Other Consultation Input

Tribes and tribal organizations offered other recommendations that did not fall directly under the four consultation questions about the standardization of VA care delivery.

Summary of Other Tribal Comments and VA Responses

In addition to recommendations on care consolidation, tribes raised the following priorities: (1) discontinuing copays for Native Veterans; (2) allowing tribal health programs to access the Consolidated Mail Order Pharmacy, as IHS does; (3) addressing the needs of urban Indians and collaborating with urban Indian health organizations; (4) creating a workgroup or VA advisory committee that includes IHS, tribal, and urban Indian health program representatives; and (5) reimbursing traditional providers. Tribal consultation input and VA responses on these topics are listed below.

Collection of Copays from Native Veterans

Tribes argue that the practice of collecting copays from Native Veterans should be discontinued.

Currently, Native Veterans who present at a VA facility are assessed copays. Tribes have previously expressed concerns that this practice is wrong, given the federal trust responsibility. IHS and tribes are the payer of last resort, whether or not there is a specific agreement in place for reimbursement. Neither the Native Veteran nor the Indian health system should be responsible for any copays. Often, Native Veterans do not go to VA facilities because of the financial burden of the required copays.

VA provided the following response on copays.

VA is required by law to assess copayments to certain Veterans who receive VA health care. VA cannot waive copayments or exempt categories of Veterans from copayment requirements without authorizing legislation. However, if IHS or a tribe will pay such a copayment on behalf of the Veteran, VA will accept the payment.

Tribal Access to the CMOP

Tribes recommend that tribal health programs be allowed to access the Consolidated Mail Order Pharmacy (CMOP).

VA contracts with IHS to access the National Supply Service Center and save federal funding on high volume prescriptions. However, VA has not extended the same opportunity to tribal health programs. Tribes are assuming and operating the same health programs previously operated by IHS, but when tribes assume operation of these IHS facilities, their access to the CMOP is terminated. Requests to VA to enter contracts with tribal health programs have been rejected thus far. There are significant cost savings to Indian health programs if VA's pharmacy services can be used, and these services would also provide alternatives to patients with transportation challenges and decrease their travel costs.

VA provided the following response on access to CMOP.

VA completed an Interagency Agreement (IAA) with IHS that enables Tribal health programs (THP) access to CMOP. It was signed on December 15, 2016. The IAA, identified by IHS with an internal administrative control number (2-OD-17-0008), provides THPs access to CMOP fulfillment services, as long as the THPs and IHS comply with the terms agreed upon in the IAA.

Addressing the Needs of Urban Indians

Tribes recommend that VA increase its ability to address the needs of urban Indians, by addressing the following concerns.

- The 2010 VA-IHS MOU states a commitment to work with urban Indian health programs, but there are currently no reimbursement agreements with any urban Indian programs.
- Urban Indian organizations that gave consultation input would be interested in providing care to non-IHS-eligible Veterans and seeing existing reimbursement agreements extended and expanded.
- VA should include urban Indian health programs and build strong relationships with them to increase the number of Native Veterans who access VA services. When asked at the National Indian Health Board conference why VA has not worked with urban Indian programs to fulfill the Federal Government's trust responsibility, VA stated that there are VA offices in urban settings and working with urban Indian programs was unnecessary. However, many urban Indians prefer to receive health care through urban Indian health programs because of shorter wait times and culturally appropriate care.
- VA's trust obligation to American Indians and Alaska Natives extends to the 70 percent of the Native population that lives in urban areas.

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The U.S. Government has a special obligation to provide health services to American Indians and Alaska Natives ... Today, 70 percent of all American Indians and Alaska Natives live in areas away from the reservation, many of whom rely on culturally relevant services like NARA. The culturally competent health care and services that NARA provides are vital to the health of our Veterans.

**—Native American Rehabilitation Association (NARA),
a Portland, OR, urban Indian health organization**

VA provided the following response on addressing the needs of urban Indians.

The legal authorities for VA's reimbursement agreements with tribal health programs are 25 U.S.C. 1645 and 38 U.S.C. 8153. Because urban Indian organizations are not included in 25 U.S.C. 1645, VA has not entered into such agreements with urban Indian organizations. However, VA's other authorities allow for urban Indian organizations to potentially become community providers. VA is willing to discuss and explore options for working with urban Indian organizations as community providers.

Establishing a Tribal Workgroup

Tribes recommend that VA establish a workgroup or tribal advisory council that includes IHS, tribal, and urban Indian representatives.

Tribes request that VA establish an IHS/tribal/urban Indian workgroup to engage in discussions and provide recommendations on issues related to the VA-IHS MOU and cooperation with IHS/tribal and urban Indian health programs. Such a process would assure that the differences among the IHS, tribal, and urban Indian health programs are recognized and addressed from the start. Indian health providers have vast experience in working through representatives to negotiate model agreements that do not displace government-to-government negotiations and individual program autonomy, but speed up the process of reaching workable solutions that can be rapidly implemented. While IHS plays a significant role in the funding and support of tribal and urban programs, it cannot be the decisive voice for them. VA should receive input directly from tribal and urban representatives, and tribal and urban representatives should be at the negotiating table with VA and IHS when VA creates agreements with IHS and tribal programs.

VA provided the following response on a tribal workgroup.

VA will consult with IHS and tribes on ways to ensure that the specific and unique needs of IHS, tribal health programs, and urban Indian representatives are recognized and addressed in future agreements.

Reimbursement for Traditional Providers

Tribes recommend that VA reimburse traditional providers.

Traditional healers are essential components of care within many tribal and urban Indian communities, and Veterans' choices should not be limited to a certain type of provider.

VA provided the following response on reimbursement for traditional providers.

The reimbursement agreements between VA and tribal health programs specify that VA will reimburse tribal health programs only for direct care services provided in the VA Medical Benefits Package available in accordance with 38 C.F.R. § 17.38 or otherwise available under statute or regulation to eligible Veterans from VA. VA would need more information to determine whether the agency can reimburse or otherwise contract for traditional healing.

VA Consultation Updates

One of the highest priorities to emerge in the Care in the Community consultation was tribes' desire to see tribal reimbursement agreements continued and extended, rather than combined with other vendors under VA's plan to standardize health care delivery among its community partners. In response to this clear statement of priority, VA proposes to extend the current reimbursement agreement through June 30, 2019. In January 2017, VA and IHS signed an amendment to the VA-IHS reimbursement agreement (originally signed between the two agencies in 2012) **extending the agreement through June 30, 2019**. Based on these amendments, reimbursement from VA to IHS sites, as well as local reimbursement agreements between tribally operated health programs and local VA medical centers, will continue throughout the extension period.

IHS announced this extension in a Dear Tribal Leader letter dated January 17, 2017, which is available online at <https://www.ihs.gov/newsroom/triballeaderletters/>. IHS also published a summary of this agreement online at <https://www.ihs.gov/newsroom/index.cfm/ihs-blog/january2017/ihs-and-va-renew-expand-partnership/>. In addition, VA and IHS also signed an interagency agreement authorizing IHS to continue using VA's mail order pharmacy services, which is also available online at the above address.

Conclusion

Through the consultation activities of 2016, VA continued to build and solidify its relationship with tribal governments as partners in delivering services to Veterans. As a result of amendments to VA's regulations about recognition of Tribal Organizations for representation of VA claimants, tribal Veterans service organizations and Veterans service officers can now be credentialed to assist Veterans with their VA benefits, increasing outreach and services to Veterans and communities in Indian Country. As a result of consultation on tribes' top three to five priorities for serving Veterans, VA has received a clear statement of tribal priorities to serve as a guide as VA continues to determine how to serve Veterans in Indian Country more effectively. Finally, as a result of consultation on a plan to standardize VA's care delivery among contracted community partners, VA has reaffirmed and extended one of its most valued mechanisms for cooperation in Indian Country: reimbursement agreements with IHS and tribal health programs. As 2016 consultations conclude, VA reaffirms its appreciation for tribal governments as partners and its respect for the government-to-government relationship that exists between VA and tribal nations.

VA recognizes the critical role that tribal governments will play, in 2017 and beyond, in reaching Veterans in and near Indian Country and acknowledges the stated desire of many tribes to work with VA in serving non-Native Veterans that live in their communities through existing tribal programs. Especially after policy and regulatory changes in 2016, tribal governments and programs are better equipped than ever before to act as an access point to VA services for Native and non-Native Veterans. VA respects tribal governments' unique capacities in this area and will continue to work with them to expand opportunities for collaboration.

With ongoing involvement from tribes, VA plans to capitalize on the existing framework for health care collaboration between VA and Indian health programs, continue engaging in consultation with tribal governments, continue providing technical assistance to tribal programs and communities, and build cooperative relationships with tribal Veterans service officers and other partners in tribal communities.

Particularly as we face an uncertain future, VA wishes to thank tribal governments for their ongoing cooperation and request their continued support and engagement in the future, as VA continues to improve the way it engages and serves Veterans in Indian Country and beyond.

Appendices

Appendix A. VA and IHS: Two Federal Commitments to Health Care

In 2016, VA's topics for tribal consultation focused indirectly and directly on health care and on the commitments the Federal Government has made about delivering health care to certain populations and beneficiaries. To understand the policy outcomes at stake in these topics for Veterans, it is important to understand the histories and missions of both VA and the Indian Health Service (IHS), the federal agency tasked with providing for American Indian and Alaska Native (AI/AN) health.

Through the missions of these two agencies, the U.S. Federal Government has made two commitments to health care: for Veterans, who have earned the benefit of health care through VA by their military service, and for American Indians and Alaska Natives, whose right to health care through IHS is grounded in the treaties, case law, and statutes.

VA's Mission: Caring for Those Who Have Borne the Battle

VA's commitment to deliver health care to qualifying Veterans is grounded in the heart of VA's mission as an agency. In 1865, during the Civil War, President Abraham Lincoln spoke to the nation in his second inaugural address, describing the country's need to heal and reconcile, and, in particular, its obligation "to care for him who shall have borne the battle and for his widow, and his orphan..." Lincoln's quote has been adopted as VA's mission statement, describing the agency's commitment to care for the needs of individual Veterans and their families, in recognition of their military service to our Nation.



Left to right: **Allegra Long**, Relationship Manager, Pacific District Veterans Experience Office; **Stephanie Birdwell**, Director, OTGR; **Majed Ibrahim**, Chief Business Office, VHA; and **Christopher Mandregan, Jr.**, Acting Deputy Director, IHS

Honoring Our Heroes:

Building Partnerships to Connect Native Veterans to Care and Benefits

Today, in reflection of the diversity of Service members, Veterans, and their families and loved ones, VA describes its mission this way:

*To care for those “who shall have borne the battle,”
and for their families and survivors.*

Since Lincoln’s words in 1865, presidents, elected officials, and VA itself have called caring for our country’s Veterans a “sacred obligation.”¹ VA takes primary responsibility for this sacred obligation, but also shares it with many other organizations and partners who contribute to ensure that Veterans’ needs are addressed as fully and efficiently as possible.

Through health care benefits, VA supports the services that promote, preserve, and restore the health of individual Veterans over the course of their lives following their military service. Health care for Veterans is delivered by the Veterans Health Administration, the largest integrated health system in the Nation, along with other contracted community providers. Currently, there are over 21 million Veterans in the United States,² and VA serves more than 9 million of them each year. VA’s health system has a history of cooperating with community providers to ensure Veterans can receive the comprehensive services they need. Over time, VA’s contracts and collaborations have created a network of providers that have longstanding relationships with VA in delivering health care to Veterans. This includes IHS facilities, tribal health programs, Department of Defense health facilities, federally qualified health centers, academic teaching affiliates, and other private and commercial partners.

The massive scale of VA’s care network and the many organizations involved have resulted “in a complex and complicated landscape that Veterans and their caregivers must navigate.”³ To best meet the needs of Veterans, providers, and VA staff, VA faces the obligation to effectively manage this complex landscape on an ongoing basis.

1 VA. (2015, February 26). Taking care of Veterans: a shared responsibility. VAntage Point: Official Blog of the U.S. Department of Veterans Affairs. Retrieved from <http://www.blogs.va.gov/VAntage/17472/taking-care-veterans-shared-responsibility/>

2 VA National Center for Veterans Analysis and Statistics. (2016). Veteran Population. Retrieved from https://www.va.gov/vetdata/veteran_population.asp

3 VA. (2016, September 12). Dear Tribal Leader letter to American Indian and Alaska Native tribes for consultation. See Appendix D (Page 50)

The Choice Act and MyVA: Connecting with the Community to Meet Veteran Needs

VA's structure for health care delivery has necessarily grown and changed dramatically throughout its history, since the first soldiers' facilities in the Civil War. Today's increasing patient population and complex health care market have sparked two new wide-scale changes that are necessary to address Veterans' health care needs: the Choice Act and MyVA.

In 2014, Congress passed the **Veterans Access, Choice, and Accountability Act of 2014⁴** (often referred to as "the Choice Act") to address problems of health care access and delays in care in VA's system. In the Choice Act, Congress provided new funding and new authority to VA to address these issues. The VA Budget and Choice Improvement Act, section 4002, required VA develop a plan to consolidate all non-VA provider programs by establishing a new, single program.

In October 2015, VA submitted to Congress the *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*. The plan described VA's vision of a consolidated community care program that would better meet the needs of Veterans, community providers, and VA staff.

With the expiration of the current Choice Act set for August 2017, the question of how VA's care network will be consolidated and transformed to better meet the health care needs of all Veterans remains a critical topic.

The **MyVA** transformation initiative, started in 2014 by VA Secretary Robert McDonald, also aims to fundamentally reimagine the way VA delivers benefits to Veterans, modernizing how the agency does business and putting Veterans in greater control of how, when, and where they receive services. MyVA articulates VA's values and vision and identifies a set of strategic actions to achieve quality and high performance in delivering services.

VA's I CARE Values

- Integrity
- Commitment
- Advocacy
- Respect
- Excellence

The MyVA vision is to provide a seamless, unified Veteran experience across the entire organization and throughout the country.

4 Public Law 113-146

MyVA is already showing success in achieving its goals, with Veterans reporting improvements in their VA experiences and increasing trust in VA as a service provider.

From 2014 to 2016, VA saw decreases in overall wait times for appointments. By late 2016, more than 90 percent of appointments met the 14-day mark, and more than 85 percent were completed within 7 days. There is also an increase in appointments being fulfilled outside of VA, due in part to the ongoing expansion of VA's network of community care options, encompassing more than 350,000 community providers.⁵

MyVA, in its current implementation and its future goals, sets VA on a trajectory to continue meeting Veterans' needs and expectations in benefits, and particularly in health care delivery, by offering flexibility and choice in where and how benefits are delivered.

IHS' Mission: Raising AI/AN Health to the Highest Levels

MyVA and the use of community providers under the Choice Act acknowledge the role that community providers play in delivering health care to Veterans. With a focus on improving Veterans' experiences through choice and flexibility, VA aims to capture the advantages that non-VA providers offer to Veterans with special circumstances, such as those who live in rural locations with few health facilities nearby.

For the approximately 140,000 American Indian and Alaska Native Veterans nationwide,⁶ some portion of which are enrolled in the VA health care system⁷ a common alternative to receiving medical care through VA is receiving care through the Indian health system. IHS is the Federal agency tasked with providing health services to eligible American Indians and Alaska Natives, and it has evolved since the 1800s out of various federal strategies to provide health care for Native populations. In the 1800s, the U.S. Government gave health services to American Indian communities through the War Department, with military physicians periodically delivering health care and infectious disease vaccinations for tribes living near military forts. In 1849, the government transferred responsibility for Indian health activities to the Bureau of Indian Affairs in the Department of the Interior, along with the first federal appropriations for Indian health. Finally, in 1955, Indian health activities moved under the U.S. Public Health Service (within the Department of Health and Human Services) and became IHS, the federal organization that administers health services for AI/AN communities today.

Another important evolution in the Indian health system has been the formal decentralization of the operation of health programs to tribal governments through self-governance.

5 VA.(2016, November).MyVA: *Putting Veterans First. Transformation Update*.p.8.Retrieved from <http://www.blogs.va.gov/VAntage/32779/va-releases-major-report-on-progress-of-myva-transformation-process/>

6 VA National Center for Veterans Analysis and Statistics. (2015, May). *American Indian and Alaska Native Veterans: 2013 American Community Survey*. Retrieved from <https://www.va.gov/vetdata/report.asp>

7 Sprenger, David. (2013). *Coordination of Benefits: Access to care for AI/AN Veterans*. Retrieved from http://www.va.gov/TRIBALGOVERNMENT/docs/resources/western_region_veterans_benefits_summit/Coordination_of_Benefits.pdf

The Indian Self-Determination and Education Assistance Act,⁸ passed in 1975, gave tribes the option to take over the administration of federally funded programs through IHS and the Bureau of Indian Affairs, and tribes quickly took advantage of this opportunity. Today, half of the Indian health care system is managed by tribal governments, and the elected leaders in tribal governments have become active, experienced, and knowledgeable participants in health advocacy and planning for their own communities.⁹ Community and local control have been recommended for the Indian health system since the earliest days of IHS as a federal department,¹⁰ and today's decentralization goes even further in allowing tribes to design programs to match regional and tribal-specific needs.

Today, IHS presides over a diverse and widely spread health network composed of three different types of providers:

- **IHS facilities**, staffed and administered directly by the federal agency;
- **tribally operated health facilities**, financed at least in part by IHS funds, but planned and self-governed by tribes; and
- **urban Indian health organizations**, funded separately under IHS to meet the health needs of American Indians and Alaska Natives who live in urban areas, often at some distance from reservation-based IHS or tribal health facilities.

The Indian health system is highly complex and diverse in its own right, but because VA has recognized IHS and tribal health programs as partners in VA's network of community care providers, the Indian health system is also part of (and contributes to the complexity of) the current landscape of VA health care delivery. Understanding the diversity of the Indian health system informs the second consultation topic of 2016 on priorities for serving Veterans in Indian Country (page 9), as tribes from different regions and different types of programs (IHS, tribal, or urban) describe the specific needs and priorities they have for meeting the health needs of their Veterans. The background on how VA and IHS work together and the goals they have in common is also critical in understanding the third consultation topic of 2016 on care in the community (page 22) and tribes' responses to VA's proposed plan to consolidate the operations of VA's network of health providers.

The 2010 VA-IHS MOU: Collaborating to Deliver Health Care to Native Veterans

In 2010, VA and IHS made a shared commitment to work together in delivering health care to Veterans through a memorandum of understanding (MOU) signed by the two agencies. The 2010 VA-IHS MOU lays out a multitude of ways to increase coordination, collaboration, and resource sharing. The MOU has served as a policy document that supports enterprise-wide cooperation to advance care for Native Veterans.

8 Public Law 93-638. Because of the public law number of the authorizing legislation, tribal health facilities that are self-governed through a contract or compact with IHS are sometimes called "638" facilities.

9 IHS. (2006). *Caring and Curing: The First 50 Years of the Indian Health Service*, p. 28. Retrieved from <https://www.ihs.gov/newsroom/factsheets/>

10 IHS, p. 8.

Honoring Our Heroes:

Building Partnerships to Connect Native Veterans to Care and Benefits

Appendix B. Dear Tribal Leader Letters: Accreditation of Veterans Service Organizations

Department of Veterans Affairs
Washington DC 20420

March 3, 2016

Dear Tribal Leader:

We are writing to facilitate Tribal consultation on the Department of Veterans Affairs' (VA) effort to improve access of Native American veterans to VA-recognized organizations and VA-accredited individuals who may assist them on their benefit claims.

VA is considering issuing a proposed rule that would amend part 14 of title 38, Code of Federal Regulations (CFR), to expressly provide for the recognition of Tribal organizations so that representatives of the organizations may assist Native American claimants in the preparation, presentation, and prosecution of their VA benefit claims. The purpose of the proposed rulemaking would be to address the needs of Native American populations who are geographically isolated from existing recognized Veterans Service Organizations or who may not be utilizing other recognized Veterans Service Organizations due to cultural barriers or lack of familiarity with those organizations.



Cheyenne & Arapaho Memorial Wall

In June 2016, the Cheyenne and Arapaho Tribes honored their past and current Active Duty and Veteran members with a ceremony honoring their service to the country and to the tribe.

The proposed rulemaking would allow the Secretary of Veterans Affairs to recognize Tribal organizations in a similar manner as the Secretary recognizes State organizations. Specifically, the proposed rulemaking would consider applications from a Tribal organization that is established and funded by one or more Tribal governments to be recognized for the purpose of providing assistance on VA benefit claims. In addition, the proposed rulemaking would allow an employee of a Tribal government to become accredited through a recognized State organization in a similar manner as VA accredits county Veterans' Service Officers who may become accredited through a recognized State organization. Finally, the proposed rulemaking would extend office space opportunities already granted to employees of State organizations who are accredited to national organizations to similar employees of Tribal organizations. We are seeking Tribal consultation regarding VA's consideration of such proposed rulemaking.

VA is also seeking comment on the potential compliance costs. In order to become accredited as a Tribal organization, the organization must show that it meets the requirements in title 38 CFR 14.628(d). Pursuant to § 14.628(d), an organization requesting recognition must: (i) "[h]ave as a primary purpose serving Veterans", (ii) "[d]emonstrate a substantial service commitment to Veterans either by showing a sizable organizational membership or by showing performance of Veterans' services to a sizable number of Veterans", (iii) "[c]ommit a significant portion of its assets to Veterans' services and have adequate funding to properly perform those services", (iv) "[m]aintain a policy and capability of providing complete claims service to each claimant requesting representation or give written notice of any limitation in its claims service with advice concerning the availability of alternative sources of claims service", and (v) "[t]ake affirmative action, including training and monitoring of accredited representatives, to ensure proper handling of claims." VA is seeking comment on the amount of time and the costs of persons' time to show that the organization meets these requirements. VA's Office of General Counsel accepts recognition requests via mail, fax, or email.

Written comments may be submitted to Tribalgovernmentconsultation@va.gov within 30 days from the date of this letter. For additional information regarding this effort, please contact Mr. Clay Ward, VA Office of Tribal Government Relations, at (202) 461-7445.

We appreciate your support and collaboration as we move forward to improve access of Native American Veterans to VA-recognized organizations and VA-accredited individuals who may assist them on their benefit claims.

Thank you for your continued support of our mission.

Sincerely,

Robert D. Snyder
Interim Chief of Staff



Appendix C. Dear Tribal Leader Letter: Priorities for Veterans

U.S. Department of Veterans Affairs

Deputy Assistant Secretary for Intergovernmental Affairs (075)

May 19, 2016

Dear Tribal Leader:

How the Department of Veterans Affairs (VA) delivers benefits and services for Veterans is growing and changing rapidly. In this environment of change, VA is more committed than ever to fulfilling its tribal consultation policy, which includes strengthening VA's relationship with tribes and consulting with tribal governments on all VA policies and actions that may impact tribes and Veterans across Indian Country.

VA wants to ensure that the needs of American Indian and Alaska Native Veterans and the priorities of tribal governments are part of these changes, now and in the future. To that end, VA is seeking input from tribal leaders **on the top 3 to 5 priorities that tribes have for serving Veterans in Indian Country**. Once identified, these priorities may be used to assist with the collaborative development of **an Indian Country Veterans Affairs policy agenda**, which will inform tribal governments, VA, members of Congress, and other Veteran-serving partners in coming years.

To gather this input, VA plans to hold two tribal consultation sessions in 2016.

The first consultation will take place **Wednesday, June 29, 2016, at 5:15 p.m.** at the Spokane Convention Center, at 334 W. Spokane Falls Blvd., Spokane, WA 99201. This session is held **in conjunction with the National Congress of American Indians (NCAI) Mid-Year Conference**, taking place June 27-30, 2016, in Spokane, WA.

The second consultation will be scheduled later this year. VA will send a second letter to confirm this session when the date and time are finalized.

VA also invites written comments on the consultation topics, particularly for tribal leaders and representatives who may be unable to attend the consultation meetings in person. Written comments may be submitted as follows:

Email: tribalgovernmentconsultation@va.gov

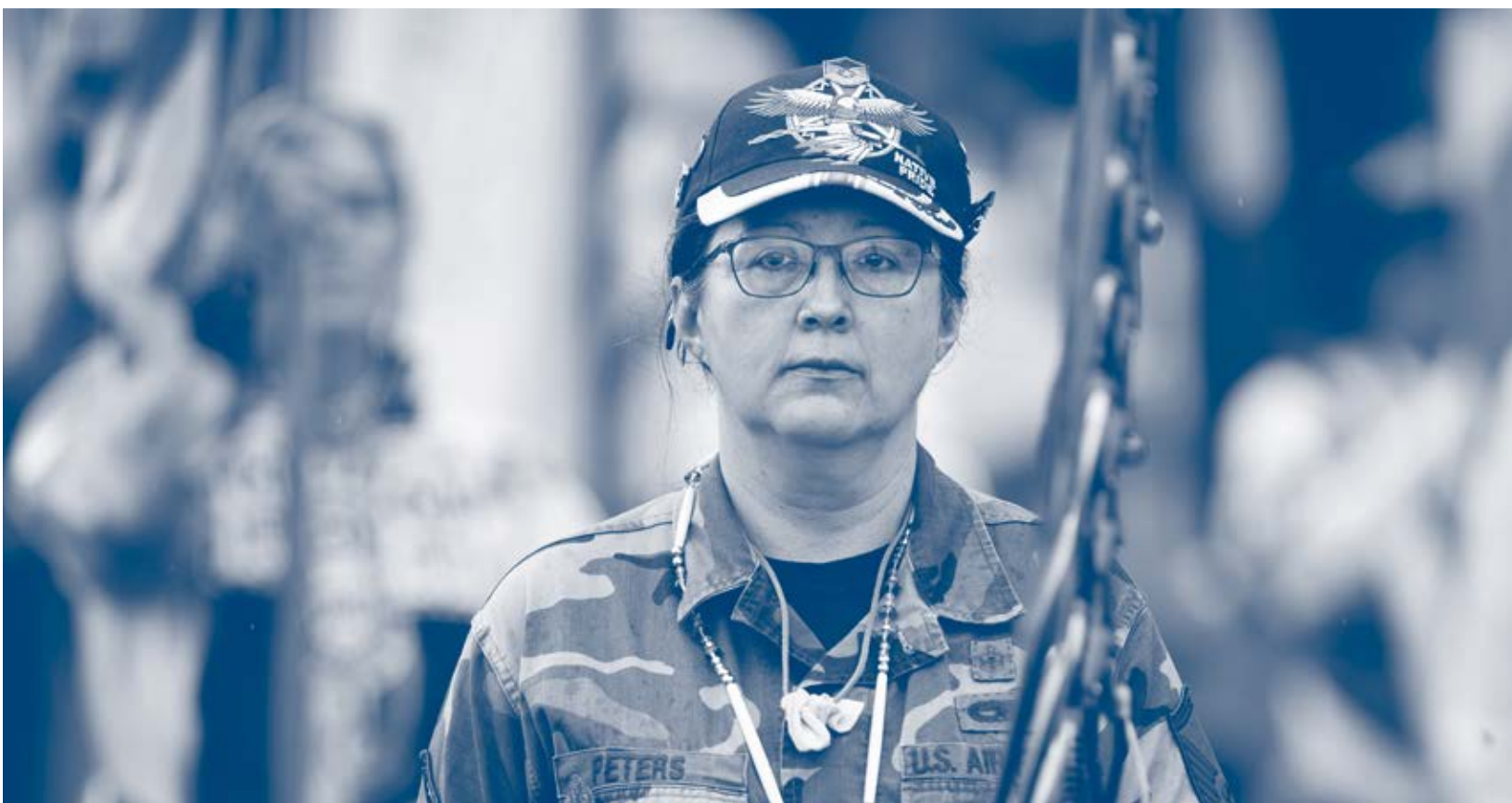
Mail: U.S. Department of Veterans Affairs
Office of Intergovernmental Affairs (075F)
810 Vermont Avenue, NW, Suite 915G
Washington, DC 20420

Written comments should be submitted no **later than October 7, 2016**. For questions, please contact VA's Office of Tribal Government Relations at 202-461-7400 or at the email address above.

VA will compile all 2016 testimony received into a tribal consultation report to be disseminated in 2017. VA wishes to thank tribal leaders for their continued support, input, and engagement as we continue our work to honor and serve American Indian and Alaska Native Veterans.

Sincerely,
James Albino

Enclosures: Priorities for Veterans fact sheet (1 pg.)



Dr. Judy Peters

With KIA/MIA POW Veteran Memorial Eagle Staff in hand, Native American Indian Veteran, First Nations Women Warriors, Dr. Judy Peters, performs in the Formal Grand Entry ceremony during the Second Annual National Gathering of American Indian Veterans.

Priorities for Veterans Fact Sheet

VA



U.S. Department
of Veterans Affairs



Office of
Tribal Government
Relations

What are your priorities for Veterans across Indian Country?

May 2016

VA wants to know the top 3–5 priorities that tribes have for serving and engaging Veterans. We are gathering input on your priorities for Veterans to help create an **Indian Country Veterans Affairs policy agenda**, which will inform tribal governments, VA, members of Congress, and other Veteran-serving partners in coming years.

This list shows the issues and priorities VA has worked to address in recent years.

What are your priorities for serving Veterans in your community? Use the list below to identify your top 3–5 priorities, or add new issues of your own.



Access to medical care

In Indian Country and for other rural areas, VA is using telehealth to expand access to care: <http://www.telehealth.va.gov/>



Suicide prevention

VA and IHS are continuing outreach to share resources and information about preventing suicide among Native Veterans.



VA and tribal or IHS facilities working together

The 2010 VA-IHS memorandum of understanding defined many ways VA and IHS can cooperate. VA has reimbursed almost \$40 million to IHS and tribal health facilities for direct care to Veterans.



VA supporting traditional providers and treatments

Some VA medical centers have added traditional treatments, like sweat lodges, for Veterans.



Treatment for PTSD and mental health

VA is using telemental health care to reach Native Veterans with PTSD and other mental health care needs:
<http://www.ruralhealth.va.gov/native/programs/telemental-services.asp>



Transportation

VA's Beneficiary Travel program reimburses mileage for travel to VA health care:
http://www.va.gov/HealthBenefits/vtp/highly_rural_transportation_grants.asp



Housing

VA's Native American Direct Loan program helps Native Veterans get low-cost home loans: <http://www.benefits.va.gov/homeloans/nadl.asp>



Understanding benefits

VA holds training summits, benefit fairs, and other events in Indian Country to help spread the word about benefits for Native Veterans.



Homelessness

VA implemented HUD-VASH, a housing voucher program, on tribal lands: <http://www.va.gov/homeless/hud-vash.asp>



Benefits for families

Some benefits are available for spouses, children, and survivors of Veterans: <http://explore.va.gov/spouses-dependents-survivors>



Employment/vocational rehab

Homeless Veteran Reintegration Program grants are available to tribes: <http://www.benefits.va.gov/vocrehab/index.asp>



Tribal consultation, listening sessions, town hall meetings

VA consults with tribes before any action that significantly affects tribal resources, rights, or lands. VA uses listening sessions and other meetings to supplement formal consultations



Tribal Veterans Representatives

Tribal Veterans Representatives (TVRs) help connect Native Veterans with VA and other community organizations: <http://www.ruralhealth.va.gov/native/programs/tribal-veterans.asp>

VA wants to hear from you. What do you think are the most important issues for Veterans living in Indian Country? Choose from the issues above, or add new priorities of your own.

My Priorities for Veterans

1. _____
2. _____
3. _____
4. _____
5. _____

Complete this form and email it back to tribalgovernmentconsultation@va.gov or send it to:

U.S. Department of Veterans Affairs, Office of Intergovernmental Affairs (075F)
810 Vermont Avenue, NW, Suite 915G, Washington, DC 20420

At a consultation, you can give it directly to any VA representatives.

Learn More About VA

Learn more about any of these programs at va.gov/tribalgovernment or www.ebenefits.va.gov/ebenefits/

Email the VA Office of Tribal Government Relations at tribalgovernmentconsultation@va.gov

Find the Office of Tribal Government Relations regional specialist for your state at va.gov/tribalgovernment/locations.asp

Appendix D. Dear Tribal Leader Letter: Care in the Community

Department of Veterans Affairs
Washington DC 20420

September 12, 2016

Dear Tribal Leader:

We are writing to facilitate tribal consultation on the Department of Veterans Affairs (VA) effort to improve continuity of care and health care access for Veterans by consolidating multiple community care, previously known as non-VA care, programs into one standard program with standard rates.

Today, VA uses multiple programs, including the Indian Health Service (IHS)/Tribal Health Program Reimbursement Agreement Program, to provide thousands of Veterans access to community care. Having multiple programs, each governed by its own set of requirements, with different payment schedules results in a complex and complicated landscape that Veterans and their caregivers must navigate. It causes confusion for Veterans, community providers, and VA staff.

In October 2015, VA submitted to Congress the *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, which lays out the vision for a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. The *Plan* incorporates feedback from key stakeholders, including VHA field leadership as well as clinicians, representing diverse groups and backgrounds. VA conducted tribal consultation in October 2015, regarding the inclusion of IHS and tribal health programs in the core provider network proposed in the *Plan*, prior to its submission to Congress.

As VA continues to move forward with implementing the vision of the *Plan*, we again seek tribal input to assist VA in developing the network of providers in a manner that would build on VA's existing relationships with tribal health programs and facilitate future collaboration to improve health care services provided to all eligible, VA-enrolled Veterans, regardless of whether they are eligible for IHS-funded health care or not. Future collaborations may focus on enhancing care options for all eligible Veterans using a single set of eligibility requirements; streamlining the manner in which VA engages with non-VA providers, including tribal health programs; standardizing clinical and business processes, including the referral process, care coordination, and health information exchange; and establishing standard reimbursement rates.

We are seeking tribal consultation regarding the tribal health programs participation in the core provider network, and potentially transitioning from the current reimbursement agreement structure to a model under which tribal health programs deliver care to all eligible, VA enrolled Veterans using a standard reimbursement rate. We would like your comments on the following questions:

1. What would be the impact of transitioning from the existing reimbursement agreement structure, which requires each tribe to enter into an individual reimbursement agreement with VA, to a standard arrangement for reimbursement of direct care services provided to eligible Veterans managed by a third-party administrator for VA?
2. Would tribal health programs be interested in expanding direct care services under this new structure to include reimbursements for care provided to all Veterans enrolled in VA health care, regardless of whether they are eligible for IHS-funded health care or not?
3. Would tribal health programs be interested in receiving standard reimbursement rates based on Medicare rates plus a feasible percentage of those rates that minimize improper payments and comply with industry standards?
4. Would tribal health programs be interested in extending existing reimbursement agreements between VA and tribal health programs through December 2018 and ensuring any new reimbursement agreements between VA and tribal health programs extend through December 2018, as VA works in collaboration with tribes and other VA stakeholders on implementing a consolidated community care program?

The in-person session of the Consultation is scheduled for Wednesday, September 28, between 9:00 AM and 11:00 AM at the Smithsonian - National Museum of the American Indian (NMAI), 4th Street & Independence Avenue, SW, Washington, DC 20560.

If you or a representative plans to attend the consultation, please RSVP to tribalgovernmentconsultation@va.gov to expedite processing through security at the NMAI and for venue planning purposes. Attendees should enter on the south doors marked "staff entrance" on 4th Street & Independence Avenue, SW.

Written comments may be submitted to tribalgovernmentconsultation@va.gov before November 5, 2016. For additional information regarding this effort please contact Majed Ibrahim at majed.ibrahim@va.gov.

We appreciate your support as we move forward to enhance and improve the experience for our Veterans.

Sincerely,
David J. Shulkin, MD



VA Community Care Fact Sheet

Tribal Health Programs—Collaborating Today for a Better Tomorrow Fact Sheet

August 2016

Since 2012, the Department of Veterans Affairs (VA) has worked closely with the Indian Health Service (IHS) and Tribal Health Programs (THP) to ensure that American Indian/Alaska Native (AI/AN) Veterans can receive care paid for by the VA in a culturally sensitive environment. VA values these collaborations and looks forward to working with IHS and THP as VA moves towards implementing a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff.

VA proposes to extend existing reimbursement agreements with IHS and THP through December 2018 and ensure any new reimbursement agreements between VA and THP extend through December 2018, so that we may conduct tribal consultation and work together to ensure VA's consolidated community care program builds on VA's existing relationships with IHS and THP.

Future Vision for VA Community Care

- Today, VA uses multiple programs to provide thousands of Veterans access to community care. Having multiple programs, each governed by its own set of requirements, with different payment schedules results in a complex and complicated landscape that Veterans and their caregivers must navigate. It causes confusion for Veterans, community providers, and VA staff.
- VA submitted the Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care (Plan) to Congress in October 2015. That plan outlines our vision to move towards an integrated health care network that delivers the best health care available through VA and community providers.
- VA collected feedback from Veterans, Veterans Service Organizations (VSOs), tribes, Federal partners, Health Care Industry Leaders, Congress, and VA Staff, and sought industry best practices to develop the Plan. Some key themes from this feedback included recommendations for:
 - ◇ Clarifying processes for accessing community care, as current processes are confusing today; and
 - ◇ VA to play an active role in care coordination for Veterans.
- Based on this feedback, the Plan proposes to simplify and consolidate all existing VA Community Care programs by rolling them into one program with a single set of eligibility requirements, streamlined clinical and business processes, and the establishment of a high-performing network of community providers and facilities.

- To successfully achieve the goal outlined in the Plan, VA is taking both a short-term and long-term approach to implement immediate fixes where we can today, while driving towards a better future state for community care.
- In creating our two-pronged approach, we looked at the Veteran's community care journey to identify five major touch points that would have the most impact on improving each Veteran's health care experience. Encompassing all of these touch points is a focus on Customer Service that aims to provide quick resolution of questions and issues.
 1. *Eligibility*: We want to provide easy-to-understand eligibility information to Veterans, community providers, and staff.
 2. *Referral and Authorizations*: We want to streamline referrals and authorizations, providing Veterans timely access to a community provider of their choice.
 3. *Care Coordination*: We want to solidify care coordination through seamless health information exchanges.
 4. *Community Care Network*: We plan to implement a Community Care Network that provides access to high-quality care inside and outside of VA.
 5. *Provider Payment (Claims)*: We want to become better partners to our community providers by paying them promptly and correctly.

VA's Community Care Network

- As part of VA's *Plan*, VA is working to build a high-performing, integrated health care network to improve Veterans' access to high-quality care both in VA and in the community.
- Reimbursement agreements with IHS and **THP** are one of the many ways in which VA purchases care for Veterans. VA wants to continue our collaborations with IHS and **THP** and work together to determine the path forward towards an integrated health care network.
- Participation in the Community Care Network could allow **THP** to provide care to and receive reimbursement for all Veterans enrolled in VA health care and served by **THP**, regardless of whether they are eligible for IHS-funded health care or not.
- VA is incorporating lessons-learned from existing community care programs and industry best practices into the Community Care Network draft request for proposal (**RFP**), which is scheduled to be out for bid in 2016. Many of these features will benefit tribal health programs, including:
 - ◇ Ensuring Veteran choice in provider selection.
 - ◇ Establishing direct communication channels between VA and community providers.
 - ◇ Standardizing and simplifying processes for sharing information between VA and community providers.

Honoring Our Heroes:

Building Partnerships to Connect Native Veterans to Care and Benefits

Next Steps

- Conduct Tribal Consultation regarding the tribal health programs participation in the core provider network, and potentially transitioning from the current reimbursement agreement structure to a model under which tribal health programs deliver care to all eligible, VA enrolled Veterans using a standard reimbursement rate.
- Continue to serve Veterans under the existing reimbursement agreements while VA engages in consultation and future planning with THP.
- Continue to work with key stakeholders to ensure that the future Community Care Network provides Veterans with a provider network that best meets their needs.



Charles Tailfeathers and Linda Woods

The Office of Tribal Government Relations co-sponsored a Native Veteran Summit/Fourth Annual Gathering of Warriors, along with the Confederated Tribes of Grand Ronde and the Native Wellness Institute during July 7-9, 2016.

Contacting VA's Office of Tribal Government Relations

Washington, DC – National Office



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VA



U.S. Department of Veterans Affairs
Office of Tribal Government Relations

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